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(1980:
Aug.)

Progress Through Partnership

Medicaid
Medicare
Management Institute

HEALTH CARE FINANCING ADMINISTRATION AUGUST, 1980 Issue # 5

MEDICAID MEDICARE EXCHANGE

NEW HCFA ADMINISTRATOR

Howard N. Newman succeeded Leonard D. Schaeffer as HCFA Administrator, effective July 7, 1980.

From 1970 until 1974 when he went to the newly organized Dartmouth-Hitchcock Medical Center, Newman was commissioner of the Medical Services Administration then responsible for the Medicaid program under HHS (formerly HEW).

Born in New York City, Newman received an AB degree from Dartmouth College in 1956; an MBA from the Amos Tuck School of Business Administration, Dartmouth, in 1957; an MS from Columbia University, School of Public Health and Administrative Medicine, in 1959; and a JD degree from Temple University Law School in 1970.

Between 1957 and 1965, Newman was with New York City's 450-bed Roosevelt Hospital as a trainee, administrative resident, administrative assistant and for four years assistant vice president responsible for the principal day to day operation of the hospital.

From 1965 to 1970 he was associate administrator of the Pennsylvania Hospital in Philadelphia. During that time he also was a White House Fellow (1967-69) and was responsible for developing a graduate program in health administration at the Institute of Health Economics for the University of Pennsylvania.

"Howard Newman's considerable experience in hospital administration, legal affairs and consumer-oriented health services make him an excellent choice for this challenging position," Secretary Harris said. "I look forward to his joining our HHS team."

Newman is affiliated with numerous professional organizations. He is a director of the Association of Academic Health Centers; a member of the advisory board, Center for Hospital Finance and Management, Johns Hopkins University Institute; a member of the steering committee of the Institute of Medicine; and a member of the Advisory Panel on National Health Insurance established by the Committee on Ways and Means, House of Representatives. Among the other groups Newman has been affiliated with are the American Hospital Association, American Management Association, the National Health Council and the President's Commission on Mental Health.

Newman's published articles have included several on Medicaid and Medicare, the Federal government's role in health care, and better hospital management. His honors and awards include the Alfred P. Sloan Foundation Exchange Fellowship and HEW's Distinguished Service Award.

MEDICARE PERFORMANCE CRITERIA AND STANDARDS

In a cooperative effort between government and the private sector, new procedures for evaluating Medicare intermediary and carrier performance have been developed. The intermediary performance criteria and standards, in effect since October 1, 1979 by Congressional mandate, were published in the June 23, 1980, Federal Register. The carrier criteria and standards, now in final stages of completion, will take effect October 1, 1980, according to administrative decision.

Both intermediaries and carriers have played key roles in developing the criteria and standards for Part A and B of Medicare through Technical Advisory Groups (TAGs) made up of contractor representatives and HCFA staff. Both review packages were field tested at contractor sites in all ten HCFA regions. In addition, the proposed Part B package was sent to all carriers for comment, and an analysis of these comments was presented by the Carrier Representative Group (CRG) at a special June meeting. A TAG subgroup appointed by the CRG met with HCFA in July to review the changes made in response to the CRG's recommendations.

According to Margaret Ingram of the Division of Standards, OSPE, "These performance criteria and standards will bring greater uniformity to the evaluation process used by each HCFA regional office. The criteria and standards contain specifically defined methods of evaluation and acceptable levels of performance. The review elements are objective and quantifiable and the methods of evaluation require examination of results or product rather than procedures or process. Where applicable, statistically valid sampling techniques are employed," she went on.

"On a yearly basis, revised criteria and standards will be issued to the contractor community in advance of the evaluation period, so that contractors will know the measures against which their performance will be evaluated and be able to take corrective actions where necessary. This new approach to contractor evaluation is expected to result in significant improvement in efficient and effective administration of the Medicare program," she concluded. Contact: Margaret Ingram, 301-594-8518.

MEDICARE ANNUAL REPORT

HCFA has published the 13th annual report describing Medicare performance for fiscal year 1979. Included in analyses of program operations are beneficiaries, health care resources, benefit payments, claims processing, contractor administrative costs, and program funding. In addition, performance in program administration, experiments, and demonstrations are reported. Copies are available from Brodie Whitlock, HCFA/OMB, D-3 Gwynn Oak Bldg., 1710 Gwynn Oak Drive, Baltimore, MD, 21235; 301-594-5514, FTS 934-5514.

REGION I CONTRACTORS REACT TO HCFA CONTACT STRATEGY PAPER

Contractor executives recommend that HCFA carefully evaluate current experimental contracts before making any widesweeping changes in Medicare contracting, attendees indicated at Region I's sixth annual Contractor Executive Conference, June 12.

The conference was attended by presidents of six New England Blue Cross and Blue Shield Plans and senior executives from the Aetna, Travelers and Connecticut General Insurance Companies. Lamont Williamson (Bureau of Program Operations), represented central office while John Kennedy, Regional Administrator, and Stanton Collins, Regional Medicare Director, headed regional participation. The conference was held at Dartmouth College's Minary Conference Center in Holderness, New Hampshire.

HCFA discussion paper, "Operating Framework for HCFA Program Administration," was principally discussed with its specific proposals to reduce the number of Medicare contractors, combine Part A and Part B contractor operations, award contracts through competition, and establish standards of performance for evaluating Medicare contractors.

In addition to evaluating current experimental contracts first, participants urged HCFA to consider each area of the country separately. Consolidation of contractor operations should be tried first where the Medicare program is being poorly administered, not where contractors are performing well. The executives emphasized that their experience and knowledge of doctors, providers and beneficiaries in the areas they service are valuable commodities to the Medicare program. They also suggested that the administrative integration of Part A and Part B would be easier to achieve if the two programs themselves were integrated first.

Attendees endorsed the concept of awarding contracts through competitive bidding but urged HCFA to be flexible in its use of this technique. They suggested HCFA not limit awards to fixed price contracts but explore a multi-faceted contracting strategy of fixed rate, fixed price plus incentive, fixed price, and the current cost reimbursement contracts.

The executives praised HCFA efforts to establish standards of performance for evaluating Medicare intermediaries and carriers. However, they recommended the standards developed to date be substantially modified to make them more objective and to decrease the effect of failure in relatively minor areas of performance on a contractor's overall performance rating.

THE MEDICARE CONTRACTOR'S CONFERENCE REPORT

IS NOW AVAILABLE

CONTACT RUTH PERRY, HCFA/M/MMI, 389 EAST HIGHRISE, 6401 SECURITY BLVD., BALTIMORE, MD 21235; 301-594-8856 FOR COPIES.

BENEFICIARY SERVICES UPDATE

Several central and regional office initiatives are well under way to improve Medicare and Medicaid services to beneficiaries.

- HCFA's Office of Beneficiary Services (OBS) is preparing a "Guide to HCFA" which identifies a number of health care issues and subjects, and lists appropriate HCFA components with their phone numbers. The guide, expected this year, should aid beneficiary organizations, advocacy groups, and others throughout the country who provide information and assistance to Medicare and Medicaid beneficiaries.

- To date 30 States have conducted 47 training sessions in a nationwide training program for volunteers to counsel Medicare beneficiaries wishing assistance in purchasing private health insurance to supplement Medicare. In this effort, OBS has developed training materials including a manual, accompanying slides for overhead projection, and a check list for regional office personnel to conduct one day programs in each State in their region.

- OBS has compiled an inventory of beneficiary services offered by HCFA regional offices, Medicaid State agencies, and Medicare carriers and intermediaries. A final report summarizing the inventory should be available in late Fall.

- A joint peer counseling program between HCFA and ACTION's Retired Senior Volunteer Program (RSVP) is also well under way. Each of the eight participating regions have conducted training sessions for 20-25 RSVP volunteers. Evaluation of the pilot peer counseling programs will take place this Fall.

As part of this effort, Region VI (Dallas) reports volunteers representing six counties attended a recent two day training session for the RSVP of east Texas. Topics included entitlement, coverage, filing claims, explanation of the EOMB and the appeals process. These volunteers will assist beneficiaries in their area in understanding program benefits and completing claims. For further information contact Bart Lacey, 214-767-6401, FTS 729-6401 in Region VI.

Details regarding OBS activities can be obtained from Barney Sellers, Director, 301-594-8131, FTS 934-8131.

INSTITUTE DIRECTOR ENTERS PRESIDENTIAL EXCHANGE PROGRAM

Mary Kenesson, first director of the Medicaid/Medicare Management Institute under HCFA's reorganization, will leave the Institute on August 1 to participate in the President's Executive Exchange Program. Under this program, senior level Federal staff obtain one year assignments in private industry. Ms. Kenesson will be replaced in mid-September by Ms. Doris Soderberg, currently Director, Office of Coverage Policy, California Department of Health Services.

Until Ms. Soderberg enters on duty, Will Wolstein, Director of the Institute's Improvements Promotion Division will also serve as Acting Director, M/MMI.

REPORT ON MEDICARE CONTRACTING

The President's Management Improvement Council released recommendations on Medicare contracting to HCFA in May. In their final report, the Council concurs with HCFA's legislative proposals and offers ten recommendations for developing an effective competitive marketplace for Medicare contracts.

In assessing HCFA's overall contracting strategy, the Council's Subcommittee on Health Care Costs consulted with various private firms, and conducted a series of "market assessment visits" with present and potential Medicare contractors. According to the report, "The most important prospect for real cost advantage in opening Medicare contracts to competition will come from the application of more sophisticated and innovative ADP systems in claims processing and in the monitoring, analysis, and control of program costs...Adoption of the recommendations should benefit the Medicare program by reducing administrative costs, providing better control over program expenditures, and improving services to beneficiaries, including faster payment of claims and responses to inquiries."

Copies of the report are available from HCFA's Bureau of Program Operations, Office of Program Administration, Division of Procurement, P.O. Box 1064, Baltimore, MD 21235; or from Irv Robinson, 301-594-8003.

COMMON AUDIT PROGRAM UPDATE

HCFA's Bureau of Program Operations reports 103 potential common audit agreements between State agencies and intermediaries (and HCFA's Office of Direct Reimbursement), as of June 30. The number of finalized agreements have nearly doubled in the last quarter, from 41 in the period ending March 31 to 79 in the period ending June 30. An additional 15 agreements have been drafted.

Common audit through exchange of information (Integration Project #3) represents one of HCFA's ongoing efforts to simplify Medicare and Medicaid administration. Effective October 1, 1979, Medicare intermediaries were instructed to negotiate common audit agreements with Medicaid State agencies, and to share information free of charge, including Medicare hospital cost reports, cost report settlements, and postadjudicative actions resulting in revised reimbursement. Also, State agencies will share any data they may have pertinent to the Medicare program.

HCFA expects several benefits from this flow of cost report information: 1) common audit procedures should promote greater efficiency in the Medicare and Medicaid provider audit programs; 2) faster receipt of information should reduce incidence of overpayments, thus reducing costs for both programs; and 3) improved relations with providers should result from the decreased number of Federal/State audits.

For further information contact Marla Frazier, BPO's Division of Performance Evaluation, 301-594-8780, FTS 934-8780.

Personnel

MEDICARE

INTERMEDIARY-CARRIER DIRECTORY UPDATE

The July Intermediary-Carrier Directory (Revision 23) should be mailed in August. The following changes were received after the copy went to print. Those who do not receive the Directory may contact the Distribution Liaison Officer, D-3 Gwynn Oak Building, 1710 Gwynn Oak Avenue, Baltimore, MD 21235.

Blue Cross of Florida
Nathan Aplinger, Vice President, Medicare A and B
Tony Provino, Director, Medicare Part A

Blue Cross/Blue Shield of Kansas City
Roger E. Crain, Vice President, Government Programs

Mutual of Omaha Insurance Company
Albert M. Hansen, Senior Executive Vice President
Frank M. Kiblinger, Regional Medicare Manager, Omaha Field Office

MEDICAID

New Medical Assistance Unit Directors

James Lewis - Maine
Donald C. Schlichtmann - Oregon

New Single State Agency Heads

Alvin J. Taylor - Florida
Edward McHugh - Massachusetts Commission for the Blind
Jon Meredith - Montana

HUD/HHS PROJECT TO HELP MENTALLY ILL

Now entering its third year, the "HUD/HHS Demonstration for the Deinstitutionalization of the Chronically Mentally Ill" is part of these agencies' response to the General Accounting Office and the President's Commission on Mental Health recommendations relating to deinstitutionalization, housing, and service for this population. A steering committee of staff from HUD and HHS (ASPE, NIMH, and HCFA) participate in each phase of the demonstration program. ASPE has carried out the coordination role for HHS.

HCFA's role in the demonstration is twofold: to provide input into each phase of the demonstration through participation in the steering committee; and, to provide Section 1115 waivers to those States requesting them, to permit Medicaid reimbursement for such services as case management, life skills, training, supervision, and transportation. Some 26 States are expected to submit waiver applications at an estimated cost of $20-30 million to provide the additional services. Waiver approval will cover each site for three years.

In this effort, HUD is providing funds for constructing and/or substantially rehabilitating permanent community based residential housing that will allow chronically mentally ill persons to live more independently. HUD has reserved approximatley $67 million in loans for private, nonprofit sponsors approved for the demonstration. Full rental assistance to the estimated 4,000 residents is also being provided by HUD.

A cost benefit evaluation has been designed. All States participating in the overall demonstration will cooperate in the evaluation, whether or not they have requested 1115 waivers. Further details may be obtained from Jean Bainter, HCFA's Office of Research, Demonstrations and Statistics, 301-594-7082 or FTS 934-7082.

PUBLICATIONS AVAILABLE TO STATES

The following reports prepared for HCFA are now available to interested State agencies:

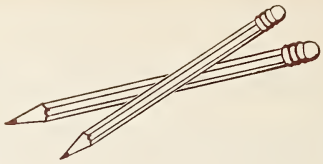
- "Evaluation of Medicaid Administrative Costs," developed by the National Institute for Advanced Studies, and conducted through the auspices of the State Medicaid Directors Council, is intended to present a better understanding of costs involved in administering the Medicaid program, and to assess the feasibility of initiating an ongoing program for detailed administrative cost data. Includes study methodology, prototype reporting system test results and recommendations, and an analysis of administrative costs.

- "An Evaluation of the Administration of the EPSDT Program in Pennsylvania," by Forward Management Associates, Inc., documents information on PA's "best practices" in EPSDT program management in an effort to facilitate an exchange of such information and methods among States. Included are an analysis of that program's efficiency and effectiveness and a profile of EPSDT contractors.

- "Study of the Issues Concerning EPSDT, and the CHAP Implementation," Volumes I, II, and III, by Health Information Designs, Inc., reviews ten years of national experience with EPSDT in terms of its potential for providing a continuum of integrated services and the program's ability to "manage" child health care. Included are providers' and States' responses.

To obtain a copy of these publications, States should contact Betty Davis, HCFA/BPO, 2-P-1 East Low Rise, Baltimore, MD 21235; 301-597-2471.

Trainers... Take Note!



The Consultation and Training Branch of the Medicaid/Medicare Management Institute has received a new shipment of 3/4" videocassettes and 16mm films on Medicare.

Introduction to Medicare (12 minutes) and Medicare and How it Helps You (31 minutes) are two classics which present a good deal of basic information about Medicare. Medicare and How it Helps You is particularly useful in working with beneficiaries, Medicare contractors, new providers and HCFA and SSA personnel. (Both are available in video-tape and film.)

Four other audiovisuals can be used for training:

o Medicare and Durable Medical Equipment (19 minutes) explains the basic provisions of durable medical equipment coverage, entitlement and reimbursement under Medicare Part B. It also provides instructions to Medicare carriers for processing such claims (available in video-tape and film).

o Determination of Reasonable Charges (8 minutes) is a useful audiovisual to show when explaining to beneficiaries, Medicare contractors, providers and HCFA and SSA personnel how Medicare decides what amount it will pay for Part B services (available in video-tape only).

The following audiovisuals are designed specifically for Social Security Office service and claims representatives:

o Date of Death Corrections (14 minutes) presents new procedures designed to reduce the error rate in processing Medicare related date of death claims (available in video-tape only).

o Name and Sex Corrections (11 minutes) explains briefly and clearly how to identify and correct name and/or sex code errors on a Medicare claim (available in video-tape only).

All six audiovisuals can be obtained from Joseph Boston, M/MMI, 301-594-8648, FTS 8-934-8648.

Some Training Tips

To assure that the training films and video-tapes maximize learning, we offer the following tips to trainers:

o The discussion leader should be extremely knowledgeable in the subject matter and should preview the film and discussion leader's guide before showing the film to trainees.

o Sufficient time needs to be allowed for full discussion of the film. It is sometimes helpful to show a film after, as well as before, the discussion. This second viewing should reinforce key points highlighted in the training session. Showing any training film without discussion is not recommended.

o The films should be seen by the trainees' supervisors. They can best insure that the lesson is correctly applied.

These training tips may be applied in using any audiovisuals.

Susan Eberhard

MASSACHUSETTS MEDICAID/IV-D EFFORT

To identify Medicaid recipients that have third party health insurance coverage, the Massachusetts Medicaid and Title IV-D child support agencies mailed an insurance questionnaire in November 1979, to the 25,000 absent parents on the IV-D files. The questionnaire asked if the absent parent maintained health insurance coverage on his/her children, and, if so, requested the carrier name, policy number, and other details of the coverage. Of the 9,000 responses received, 2,500 reported some health insurance coverage on the children. Approximately 60 percent of the 2,500 were new cases not already in the Medicaid third party resource file. The State estimates third party savings of $300,000 from this project. For additional information, contact Greg Breslin of the Massachusetts Medical Assistance program, at 617-727-0780.

PUBLIC MEETINGS ON SNF AND ICF REGULATIONS

Each regional office will hold a public meeting on conditions of participation for skilled nursing and intermediate care facilities. Meetings will be scheduled during the 60-day comment period for the proposed regulations, published in July 14 Federal Register. In this way, interested organizations and individuals will have an opportunity to express their views and concerns before final regulations are issued.

MMMI EVENTS

Fiscal Intermediary Group Meeting
Sept. 9-10, 1980 Baltimore, MD
Contact: Paul Beller
301-594-9523
FTS 934-9523

State Medicaid Group Meeting
Sept. 16, 1980 Washington, D.C.
Contact: Ed Palder
301-594-8940
FTS 934-8940

Carrier Representative Group Meeting
Oct. 2, 1980 Baltimore, MD
Contact: Paul Beller
301-594-9523
FTS 934-9523

Mid-Year State Medicaid Directors Conference
Dec. 2-3, 1980 San Antonio, TX
Contact: Ed Palder
301-594-8940
FTS 934-8940

Several other M/MMI programs are planned, but dates are not yet finalized. They include:

for Fall 1980 -

National SURS User Workshop
Sept. 23-26, 1980 Denver, CO
Contact: Du'Va Clyburn
301-594-8648
FTS 934-8648

for the upcoming fiscal year -

Joint OFA/SSA Eligibility Workshop; Third Party Liability Workshop; PSRO Workshops; and EPSDT Workshops

READERS ARE ADVISED TO WATCH THIS SPACE FOR UPDATED SCHEDULES OF EVENTS.

REGULATION

Following are recent HCFA regulations of interest to Medicaid and Medicare program managers. Questions may be directed to the contact persons listed with each regulation.

Especially significant is a notice of regulation plan appearing in the June 12 Federal Register. This new regulation management system includes a process for developing a regulation plan at the beginning of each fiscal year. Each initiative is designed to achieve specific programmatic goals and objectives according to priorities. The plan includes a projected schedule for publishing each initiative in priority order.

Medicare and Medicaid Programs; Medicare and Medicaid Disclosure of Provider Information and Access to Provider Records - Correction Notice
5/9/80 Federal Register - Effective July 17, 1979
Contact: Martha Moser, 301-594-9633

Medicare Program; Assistance Agreements to End Stage Renal Disease Network Coordinating Councils - Notice of Decision to Develop Regulation
5/9/80 Federal Register
Contact: Spencer Schron, 301-594-0918

Medicaid and PSRO Programs; Medicaid Provider Records and Grants to Professional Standards Review Organizations: Technical Amendments - Final Regulation
5/9/80 Federal Register - Effective 5/9/80
Contact: Lenore Katz, 301-594-1322

Medicare Program; Reasonable Charge Limitations - Notice of Decision to Develop Regulation
5/29/80 Federal Register
Contact: Paul Riesel, 301-594-1843

Medicare Program; Hospital Insurance Entitlement and Benefits - Proposed Regulation
5/30/80 Federal Register - Comments due 7/29/80
Contact: Harold Fishman (eligibility policy), 301-594-9077; Martin Horowitz (coverage policy), 301-594-9823

Medicaid Program; Common Medicaid-Medicare Audit Requirements for Hospitals - Proposed Regulation
6/3/80 Federal Register - Comments due 8/4/80
Contact: Don Novitski, 301-594-9063

Medicare Program; Schedules of Guidelines for Respiratory Therapy Services - Final Notice
6/3/80 Federal Register - Effective dates vary by State
Contact: William Goeller, 301-597-1802

Medicare and Medicaid Programs; Prohibition Against Payment for Less Than Effective Drugs - Proposed Regulation
6/5/80 Federal Register - Comments due 8/4/80
Contact: Marinos Svolos, 301-594-6719

Medicare and Medicaid Programs; Schedule of Limits on Home Health Agency Costs Per Visit - Final Notice
6/5/80 Federal Register - Effective 7/1/80 (see next entry)
Contact: Carl Slutter, 301-594-9344

Medicare and Medicaid Programs; Schedule of Limits on Home Health Agency Costs Per Visit - Correction Notice
6/23/80 Federal Register
Contact: Carl Slutter, 301-594-9344

HCFA; Fiscal Year 1980 Regulation Plan - Notice of Regulation Plan
6/12/80 Federal Register - Comment period open
Contact: Jodi Dunn, 301-594-7952

Medicaid Program; Medicaid Overpayment Reporting Requirements - Notice of Decision to Develop Regulation
6/12/80 Federal Register (see next entry)
Contact: Guy L. Harriman, 301-594-8193

Medicaid Program; Medicaid Overpayment Reporting Requirements - Correction Notice
6/20/80 Federal Register
Contact: Guy L. Harriman, 301-594-8193

Medicare Program; Clarification of Urban Location Classification in New England - Final Notice
6/18/80 Federal Register - Effective 7/1/80
Contact: Carl Slutter, 301-594-9344

Medicare Program; Schedule of Limits on Skilled Nursing Facility Inpatient Routine Service Costs - Proposed Notice
6/18/80 Federal Register - Comments due 8/18/80
Contact: Carl Slutter, 301-594-9344

Medicare Program; Reimbursement of Hospital Based Physicians - General Notice
6/20/80 Federal Register
Contact: William Birnie, 301-594-5431

Medicare Program; Schedule of Limits on Hospital Inpatient General Routine Operating Costs for Cost Reporting Periods Beginning on or after July 1, 1980 - Final Notice
6/20/80 Federal Register - Effective 7/1/80
Contact: Carl Slutter, 301-594-9344

Medicare and Medicaid Programs; Conditions of Participation: Hospitals - Proposed Regulation
6/20/80 Federal Register - Comments due 8/19/80
Contact: Janet Harryman, 301-594-9712

Medicare Program; Intermediary Nominations, Contracts, Evaluations, and Notices - Final Regulation
6/23/80 Federal Register - Effective 6/19/80
Contact: Irvin Robinson, 301-594-8003

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MASSACHUSETTS BLUE CROSS HOSPICE DEMONSTRATION

Blue Cross of Massachusetts will fund a 24 month pilot hospice program, beginning November 1. In this demonstration, Blue Cross will award up to five contracts to hospice care providers for a wide range of services to subscribers.

As in HCFA's national hospice demonstration (MMX #3), Massachusetts Blue Cross plans to evaluate various methods of delivering such care, and provide data from which they can determine how best to cover hospice services after the study period. Applicants were advised to structure their proposals as either an institution based program (hospital or SNF), a coordinated home health agency, or an independent agency. Due July 18, some 20 proposals were received.

The standards of care for this pilot incorporate those developed by the Standards and Licensure Task Force of the Regional Cancer Control Committee's Hospice Subcommittee in Massachusetts. The standards include sections on scope of service, administration, admission criteria, family and patient care planning, record keeping and training. For further information contact Peggy Erlanger, Massachusetts Blue Cross, 617-956-2500.

REGULATION REVIEW - continued

Medicare Program; Statistical Standards for Evaluating Intermediary Performance During Fiscal Year 1980 - Final Notice with Comment Period
6/23/80 Federal Register - Comments due 8/18/80 - Effective 6/19/80
Contact: Newton Dikoff, 301-594-8190

Medicaid Program; Medicaid Agency Fraud Detection and Investigation Program: Verification of Services - Notice of Deferral Action on Final Regulation
6/27/80 Federal Register
Contact: James F. Patton, 301-594-8000

Medicare Program; Economic Index for Physicians' Services for the Period July 1, 1980 Through June 30, 1981 - Final Notice
6/27/80 Federal Register - Effective 7/1/80
Contact: Paul Riesel, 301-597-1843; or Joseph Romano, 301-594-1023

Medicare Program; Payment for Durable Medical Equipment - Final Regulation
7/1/80 Federal Register - Effective 12/29/80
Contact: Paul Riesel, 301-597-1843

Medicaid and Medicare Programs; Conditions of Participation for Skilled Nursing Facilities and Intermediate Care Facilities
Proposed Regulation
7/14/80 Federal Register - Comments due 9/11/80
Contact: J. Richard Lenehan, Jr., 301-594-7651

Legislative Ledger

The following bills have recently been signed into law by the President:

. H.R. 3236, the Social Security Disability Amendments of 1980, was signed June 9 to become P.L. 96-265. The new law makes a number of disability benefit and eligibility changes under Titles II and XVI beginning July 1 of this year, along with a Medigap provision establishing a voluntary certification of supplemental Medicare policies by HHS in 1982.

. H.R. 3434, the Adoption Assistance and Child Welfare Act of 1980, (formerly referred to as the Social Services and Child Welfare Amendments), was signed June 17 to become P.L. 96-272. The bill establishes a new program of adoption assistance for hard to place children, limits open-ended funding for foster care, and makes significant changes in the Title XX social services program. Three provisions that affect HCFA programs are: 1) limitation on period for State filing of claims under the Social Security Act (Sec. 306); 2) exchange of information on terminated or suspended providers under Medicare and Medicaid programs (Sec. 308); and 3) continuation of Medicaid eligibility for certain recipients of VA pensions (Sec. 310).

. H.R. 10, Rights of the Institutionalized, was signed May 23 to become P.L. 96-247. The bill would protect the civil rights of institutionalized persons.

Other recent congressional activities of interest to Medicaid and Medicare managers follow.

On June 30, by a vote of 89 to 0, the Senate adopted S.2885, the "Reconciliation Act of 1980." The bill includes savings measures for the Medicare, Medicaid, and PSRO programs (basically the same measures contained in H.R. 934, the Medicare and Medicaid Administrative and Reimbursement Reform Act of 1979, which had previously been reported by the Senate Finance Committee), but does not include Medicare and Medicaid cost items. Some of those items contained in S.2885 that most directly affect HCFA programs are: 1) criteria for determining reasonable cost of hospital services; 2) closure and conversion of underutilized facilities; 3) certain surgical procedures performed on an ambulatory basis; 4) access to and purchase of certain Medicaid services; and 5) determination of reasonable charges under Medicare.

June hearings on H.R. 6194, the Medicaid Community Care Act of 1980, were held by the Health Subcommittee of the House Commerce Committee. This bill would increase the Federal Medicaid matching rate for States to provide community based noninstitutional care to persons otherwise likely to need nursing home care. Hearings focused on providers of long term care services after appearances by beneficiaries and State and local officials. Since Health Subcommittee Chairman Henry Waxman (D-CA) introduced the bill in December, 120 House members have joined as cosponsors. The Subcommittee heard from representatives of home health associations who supported H.R. 6194 and a national policy on home care, while deploring the present bias towards institutional care. Another panel testifying for the nursing home industry supported development of community care services, not as an alternative to institutional care, but as another part of long term care.

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ACTION

These Action Transmittals have been issued by HCFA in May and June. States desiring copies may order them by calling 301-594-5519.

AT-80-34 Regulation
Title XIX Social Security Act: Medicaid Program
(refer to 42 CFR Subchapter C)

AT-80-35 Notice
Title XIX Social Security Act: Medicaid Reimbursement Survey

AT-80-36 Program Instruction
Clarification of Exhibit A-3, Number 39, Rounding Policy for Consistency of Entries, MQC Manual 4000 (Effective June 9, 1980)

AT-80-37 Reporting Requirement
Affirmation of continuing reporting requirements for quarterly statements of financial plans (OA-25A and OA-25.5). The report is to be received by the Bureau of Program Operations in Baltimore, MD no later than 45 days before the beginning of the forthcoming quarter.

AT-80-38 Program Instruction
Revision of Complete Text of Preprinted State Plan

AT-80-39 Monthly Report of Physicians/Practioners, Providers, and/or Other Suppliers of Health Care Services Suspended, Reinstated, Excluded, Terminated, Reinstated, or Where Effectuated Sanction was Withdrawn.

AT-80-40 Monthly Report of Physicians/Practitioners, Providers, and/or Other Suppliers of Health Care Services Suspended, Reinstated, Excluded, Terminated, Reinstated, or Where Effectuated Sanction was Withdrawn.

AT-80-41 Program Instruction
AFDC and SSI Strata Cases Which Do Not Appear on the Medicaid Eligibility File

AT-80-42 Program Instruction
Change in Medicaid Quality Control Methodology

AT-80-43 Proposed Regulation
Title XIX Social Security Act: Common Medicaid-Medicare Audit Requirements for Hospitals (refer to 42 CFR 447.200, 447.202)

AT-80-44 MQC Manual Changes

1) Liability Errors Applicable to all States

2) States with Administrative Periods Less Than 60 Days

3) Cases Where Beneficiaries Failed to Meet Computed Liability Prior to Medicaid Certification

4) Change in Administrative Period for Death Cases

TRANSMITTALS

AT-80-45 Proposed Regulation
Titles XVIII and XIX Social Security Act: Prohibition Against Payment for Less Than Effective Drugs (refer to 42 CFR, Parts 405 and 441)

AT-80-46 Policy Clarification
The Periodic Interim Payment Method of Reimbursement Under Title XIX

AT-80-47 Reporting Requirement
Revised Reporting Requirement for Quarterly Statements of Financial Plan (OLD OA-25) and Quarterly Estimate of Expenditures

AT-80-48 Monthly Report of Physicians/Practitioners, Providers, and/or Other Suppliers of Health Care Services Suspended, Excluded, Terminated, Reinstated, or Where Effectuated Sanction was Withdrawn

AT-80-49 Proposed Regulation
Title XVIII Social Security Act: Medicare Program - Hospital Insurance Entitlement and Benefits, Recodification of Regulations (refer to CFR 42 CFR 405.102 through 405.133, 405.161, 405.180, and 405.181; proposed new CFR Part 408, Subpart A and Part 409, Subpart A)

AT-80-50 Program Instruction
Title XIX Social Security Act: Medicaid Eligibility of Recent Cuban/Haitian Entrants

NATIONAL COMMISSION ON SOCIAL SECURITY

Medicare and Medicaid issues highlighted a July meeting of the National Commission on Social Security. Under the Social Security Amendments of 1977, the nine member, "high level, nonpartisan, independent" body was charged with conducting a two year study of the Social Security programs, including: 1) the fiscal status and adequacy of trust funds; 2) scope of coverage, adequacy of benefits, conditions of qualifications for benefits and quality of administration; 3) impact of the programs on and relation to public assistance programs and medical service delivery systems; and 4) alternatives to current programs.

In addition, the Commission will study the need to develop a special Consumer Price Index for the elderly. A final report to the President and Congress is scheduled for release January 11, 1981. For further information contact Melanie McClintock, NCSS, 202-376-2622.

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LEGISLATIVE LEDGER - continued

On June 30, the Supreme Court on a vote of 5 to 4 upheld as Constitutional the Hyde Amendment which prohibits spending Federal Medicaid funds for abortions except to save the life of the mother and in cases of rape or incest. The Court also ruled that State Medicaid programs are required to finance abortions only when Federal funds are available. The decision overturns a ruling on February 19 by U.S. District Court Judge John F. Dooling, Jr. of Brooklyn that declared the Hyde Amendment unconstitutional and resulted in resumption by HCFA of Medicaid financing for medically necessary abortions under the District Court order only through the last week of July, when the Supreme Court ruling became effective. The agency is bound by the final abortion regulations which had been suspended since February 19 pending the Supreme Court ruling.

For further information on these or other HCFA legislative issues call Richard Chambers, HCFA's Legislative Reference Office, 202-426-3717.

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